



# How to Request an Exception or Appeal a Decision From Your Prescription Drug Plan



Sometimes you may not be able to obtain a prescription medication that your healthcare provider (prescriber) has ordered for you. For example, your health plan might not cover the drug because it is not on the plan's drug list (formulary), or the cost is higher than you think you should have to pay.

In these situations, you and your prescriber have the right to ask the health plan to explain its decision and to consider making the drug available to you as an exception to its policies. Exception requests are common processes for prescription drug plans, especially when medicines enter the market and they are not on your plan's list of covered drugs. This guide has been developed to help you understand:

- What prior authorization?
- How to request an exception
- How to appeal if the exception request is denied
- Where to find more information

## Prior Authorization

### What is Prior Authorization?

Prior authorization (also called pre-authorization or pre-certification) is the process used by health plans to ensure that a product or service meets their coverage criteria before it is provided. As part of this process your prescriber must contact the plan and describe the medical reason that you need that particular item. Prior authorization is a common plan requirement, particularly for specialty and costly drugs, and your prescriber will likely be familiar with the process. If for some reason you or your prescriber feel that you cannot meet your plan's prior authorization requirements for a drug you need, you have the right to request an exception to the plan's policy.

## Exceptions

### What is an Exception?

An exception is a special request for a plan to cover something outside of its usual coverage policies. For prescription drug benefits, an exception request can apply in a number of situations:

- A drug that you need is not on the plan's formulary
- You or your prescriber feel that you cannot meet the plan's coverage rules or requirements for the drug you need
- The lower tier drug on the plan's formulary is not appropriate for you, and you would like the plan to cover the higher tier drug at the lower cost sharing amount

### The Exceptions Process

Most health plans have similar general rules for making exceptions requests:

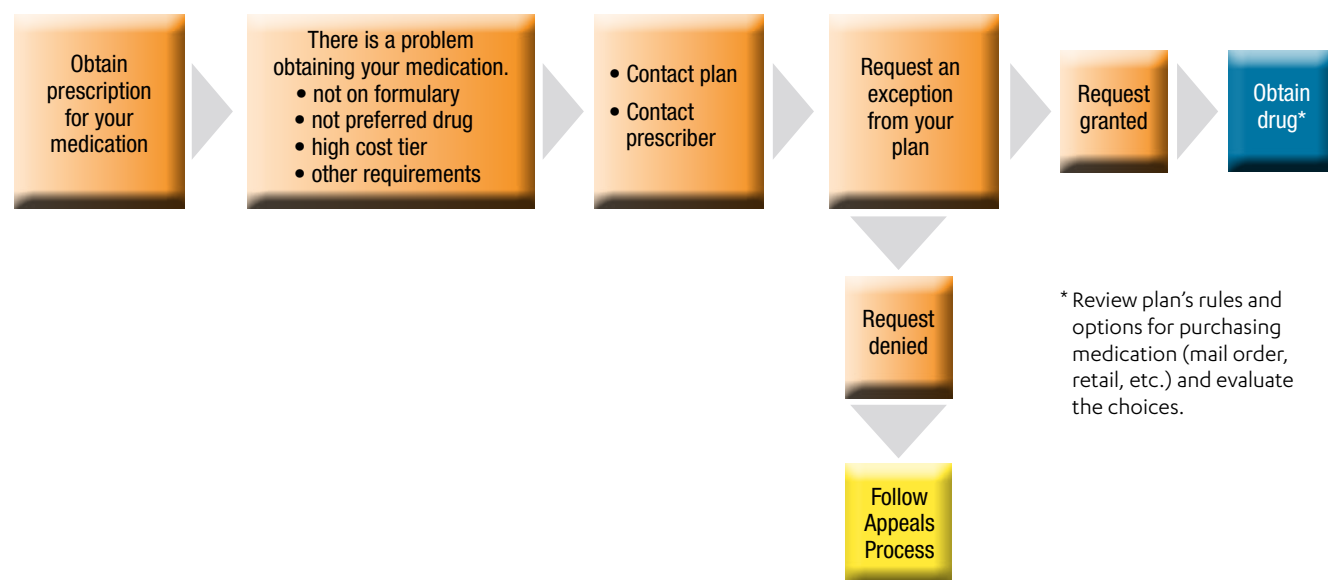
- You, your prescriber or a representative that you appoint may make the request on your behalf
- The request must be made in writing (some plans require use of a specific form; others will specify the information to include in a letter of request.)
- Your prescriber will need to write a supporting statement, explaining the medical reason for the exception request
- A faster process (expedited, rather than standard) is available for situations where not receiving your medication could be harmful to your health

To start the exceptions process, first contact your health plan and ask about the requirements. Find out if you need to use any specific forms to file your request. If the plan representative seems unfamiliar with the terms "exception" or "exception request," it may be helpful to explain what you are trying to do. For example, saying something like "My doctor prescribed a medication for me but I cannot get it because it is not on your list of covered drugs. What should I do?" may assist the representative to find the needed information or refer you to someone else who can help. The plan will need supporting information from your prescriber so it is helpful to notify your prescriber as soon as possible. Tell them that your prescription was denied and that you would like to request an exception. Your prescriber may be able to work directly with your plan to help you obtain coverage for your medication.

## Exception Determination

Your drug plan is required to respond to an exception request within specific time frames. That time begins when the plan receives your prescriber's supporting information. The amount of time varies with whether the request was for a regular (standard) or fast (expedited) process. For Medicare Part D plans, a standard request must be answered within 72 hours and an expedited request, within 24 hours. The plan will provide you with a written decision. If your request is not approved, the plan will explain why it was denied and how to request an appeal if you disagree with the decision. The following chart illustrates the process for requesting an exception:

### The Exceptions Process



## Appeals

### What is an Appeal?

An appeal is a request for a health plan to reconsider a coverage denial. If your plan does not grant your exception request, you have the right to appeal. The information that is provided from your plan regarding your initial denial will explain how to start the appeals process. If it is not clear, or you have any questions, contact your plan directly for help.

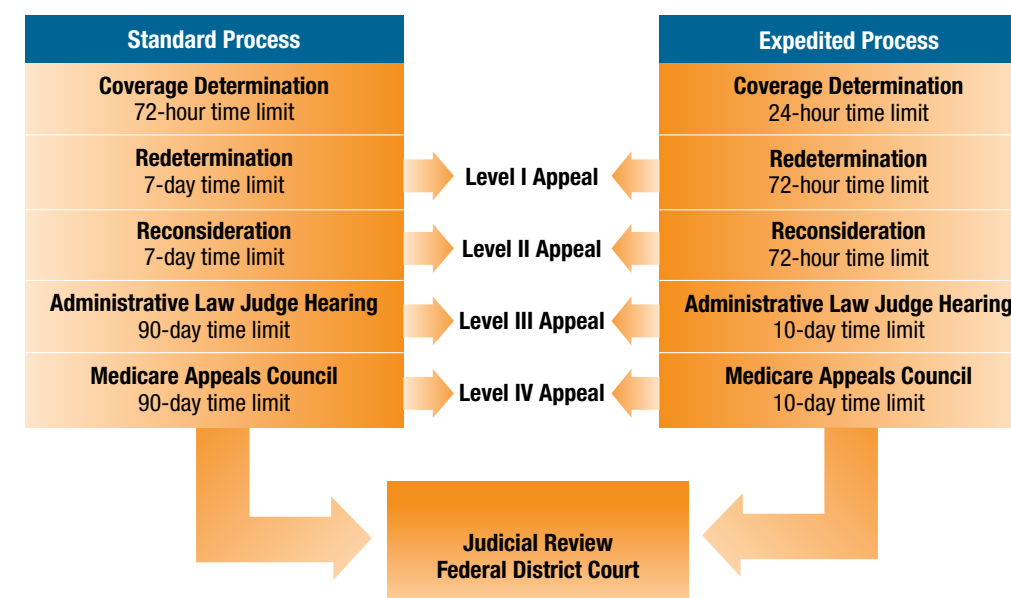
## The Appeals Process

An appeals process generally has a number of levels. If you disagree with the decision made at any level, you can usually go on to the next. The Medicare Part D appeals process has five levels. Outside of Medicare, your health plan may have an appeals process that is just for that plan. It is important to contact your plan, review the requirements and obtain any forms that the plan may want you to use. Most plans have similar rules for filing appeals:

- You, your prescriber or a representative that you appoint may file the appeal on your behalf
- The request must be made in writing (some plans require use of a specific form; others will specify the information to include in a letter of request)
- Your prescriber will need to write a supporting statement, explaining the medical reason for the appeal
- A faster (expedited) process is available if it is determined that not receiving your medication could be harmful for you
- The steps of the appeals process must be followed in order
- You must also follow the timelines for each level

The following diagram illustrates the Medicare Part D appeals process:

### Medicare Part D: Steps in the Coverage Determination and Appeals Process



NOTE: A request for a coverage determination may be made for tiering or formulary exception and may be filed by the patient, their appointed representative or the prescriber. The time frame begins when the plan receives the prescriber's supporting statement. Sixty (60) days are allowed for filing at each level of appeal.

Adapted from CMS website at: [http://www.cms.gov/MedPrescriptDrugApplGriev/01\\_Overview.asp](http://www.cms.gov/MedPrescriptDrugApplGriev/01_Overview.asp). Accessed April 8, 2013.

## Checklist

Steps toward obtaining my medication:	Yes	No
1 I have been notified that my medication is not covered because it is not on the formulary or that I will need to pay a high price or meet other requirements before obtaining it . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
2 I have asked my health plan what I need to do to ask for an exception and for any forms that are required. . . . .	<input type="checkbox"/>	<input type="checkbox"/>
3 My prescriber is aware and has agreed to submit any needed information to my insurance company . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
4 I understand the deadlines that must be followed to submit my request. . . . .	<input type="checkbox"/>	<input type="checkbox"/>
5 I understand that if my request for an exception is denied, I have the right to appeal. . . . .	<input type="checkbox"/>	<input type="checkbox"/>
6 I am aware of the available options for purchasing my medication (mail order, retail pharmacy, etc.) and have evaluated the choices. . . . .	<input type="checkbox"/>	<input type="checkbox"/>

## Medicare/Medicaid Resources

Resource	Phone	Website
Centers for Medicare & Medicaid Services (CMS) Exceptions and Appeals Processes	1-800-MEDICARE (633-4227)	<a href="http://www.cms.gov/MedPrescriptDrugApplGriev">http://www.cms.gov/MedPrescriptDrugApplGriev</a>
Medicare Appeals booklet	1-800-MEDICARE (633-4227)	<a href="http://www.medicare.gov/publications">www.medicare.gov/publications</a> enter "appeals" in search box
Medicare & You 2013	1-800-MEDICARE (633-4227)	<a href="http://www.medicare.gov/publications/pubs/pdf/10050.pdf">www.medicare.gov/publications/pubs/pdf/10050.pdf</a>
Forms	1-800-MEDICARE (633-4227)	<a href="http://www.cms.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/Forms.html">http://www.cms.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/Forms.html</a>
Medicaid Exceptions and Appeals Processes	State-specific toll-free numbers	<a href="http://www.medicare.gov/contacts">http://www.medicare.gov/contacts</a> to access contact information by state
State Health Insurance Assistance Program (SHIP)	1-800-MEDICARE (633-4227)	<a href="http://www.medicare.gov/contacts">www.medicare.gov/contacts</a> to obtain state-specific contact number

# Summary

- If your prescribed medication is not on your plan's formulary, or if you will have to pay a high cost based on its formulary position, or if you cannot meet other requirements, you may request an exception to your plan's coverage policies
- Information about the exceptions process is available from each health plan and may be found in your benefits manual, at the plan's website, or by calling the customer service number usually found on the back of your prescription drug card
- Not everyone at your plan may be familiar with the term "exceptions request" so you may have to describe, even more than once, your situation and what you are trying to accomplish before reaching someone that can assist you
- If your exception request is denied, you have the right to appeal the decision
- Information about the appeals process should be given to you in your denial letter. You can also obtain that information from the plan's website or by calling customer service
- Remember that each step of the appeals process must be followed exactly within the specified timeframes
- Once coverage for your medication is approved, carefully review and select your plan's options for obtaining it, taking in to consideration cost and convenience factors

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